Department of Veterans Affairs
Office of Inspector General

Combined Assessment Program Review of the Central Texas Veterans Health Care System Temple, Texas

Report No. 04-03403-133 **May 5, 2005**

VA Office of Inspector General
Washington, DC 20420

Office of Inspector General

Combined Assessment Program Reviews

Combined Assessment Program (CAP) reviews are part of the Office of Inspector General's (OIG's) efforts to ensure that high quality health care and benefits services are provided to our Nation's veterans. CAP reviews combine the knowledge and skills of the OIG's Offices of Healthcare Inspections, Audit, and Investigations to provide collaborative assessments of VA medical facilities and regional offices on a cyclical basis. The purposes of CAP reviews are to:

- Evaluate how well VA facilities are accomplishing their missions of providing veterans convenient access to high quality medical and benefits services.
- Determine if management controls ensure compliance with regulations and VA policies, assist management in achieving program goals, and minimize vulnerability to fraud, waste, and abuse.
- Provide fraud and integrity awareness training to increase employee understanding of the potential for program fraud and the requirement to refer suspected criminal activity to the OIG.

In addition to this typical coverage, CAP reviews may examine issues or allegations referred by VA employees, patients, Members of Congress, or others.

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Executive Summary

Introduction

During the week of January 10–14, 2005, the Office of Inspector General (OIG) conducted a Combined Assessment Program (CAP) review of the Central Texas Veterans Health Care System. The purpose of the review was to evaluate selected operations, focusing on patient care administration, quality management (QM), and financial and administrative controls. During the review, we also provided fraud and integrity awareness training to 231 employees. The health care system is under the jurisdiction of Veterans Integrated Service Network (VISN) 17.

Results of Review

The CAP review covered 10 areas. As indicated below, the health care system complied with standards in six areas. The remaining four areas resulted in recommendations for improvement.

The health care system complied with selected standards in the following areas:

- Controlled Substances
- Emergency Preparedness
- Environment of Care
- Government Purchase Card Program
- Information Technology Security
- Pressure Ulcer Management

Based on our review, we identified the following organizational strength:

- State-of-the-Art Psychiatric Unit

We identified four areas which needed additional management attention. To improve operations, the following recommendations were made:

- Improve the QM program performance improvement and review processes.
- Strengthen controls for service contracts.
- Strengthen supply inventory management.
- Increase Medical Care Collections Fund (MCCF) collections by improving documentation and billing procedures.

This report was prepared under the direction of Ms. Linda DeLong, Director, Dallas Regional Office of Healthcare Inspections.

VISN 17 and Health Care System Director Comments

The VISN and Health Care System Directors agreed with the findings and recommendations and provided acceptable implementation plans. (See Appendixes A and B, pages 10–17, for the full text of the Directors' comments). We will follow up on planned actions until they are completed.

(original signed by:)
RICHARD J. GRIFFIN
Inspector General

Introduction

Health Care System Profile

Organization. The Central Texas Veterans Health Care System consists of two divisions in Temple and Waco, TX, and provides tertiary medical, surgical, psychiatric, blind rehabilitation, long-term care, and outpatient services. The health care system is part of the VA Heart of Texas Health Care Network (VISN 17) and serves a population of approximately 235,000 veterans residing in 39 counties in central Texas.

Programs. The Temple Division is a 717-bed tertiary care facility providing a broad range of inpatient and outpatient services in medicine, surgery, long-term care, psychiatry, and rehabilitation. The Waco Division is a 362-bed psychiatric facility providing inpatient and outpatient services in medicine, surgery, long-term care, blind rehabilitation, and psychiatry.

Affiliations and Research. The health care system is affiliated with the Texas A&M University College of Medicine and supports 31 medical resident positions in medicine, surgery, psychiatry, pathology, radiology, and dentistry training programs. The health care system is also affiliated with other allied health colleges and universities to provide clinical training opportunities for nursing, pharmacy, physical and occupational therapy, dietetics, respiratory therapy, recreation therapy, and allied health students.

Resources. The health care system's fiscal year (FY) 2004 medical care budget was $326.2 million. FY 2004 staffing was 2,662.2 full-time equivalent employees (FTE), including 145.2 physician and 446 nursing FTE.

Workload. The health care system treated 62,688 unique patients in FY 2004. The health care system reported 7,070 inpatient discharges and 730,026 outpatient visits in FY 2004.

Objectives and Scope of the CAP Review

Objectives. CAP reviews are one element of the OIG's efforts to ensure that our Nation's veterans receive high quality VA health care and benefits services. The objectives of the CAP review are to:

- Conduct recurring evaluations of selected health care facility and regional office operations focusing on patient care, QM, benefits, and financial and administrative controls.
- Provide fraud and integrity awareness training to increase employee understanding of the potential for program fraud and the requirement to refer suspected criminal activity to the OIG.

Scope. We reviewed selected clinical, financial, and administrative activities to evaluate the effectiveness of patient care administration, QM, and management controls. Patient care administration is the process of planning and delivering patient care. QM is the process of monitoring the quality of care to identify and correct harmful and potentially harmful practices and conditions. Management controls are the policies, procedures, and information systems used to safeguard assets, prevent errors and fraud, and ensure that organizational goals are met.

In performing the review, we inspected work areas; interviewed managers, employees, and patients; and reviewed clinical, financial, and administrative records. The review covered the following 10 activities:

Controlled Substances	Medical Care Collections Fund
Emergency Preparedness	Pressure Ulcer Management
Environment of Care	Quality Management
Government Purchase Card Program	Service Contracts
Information Technology Security	Supply Inventory Management

The review covered health care system operations for FY 2003, FY 2004, and FY 2005 through January 13, 2005, and was done in accordance with OIG standard operating procedures for CAP reviews.

Activities that were particularly effective or otherwise noteworthy are recognized in the Organizational Strength section of this report (page 3). Activities needing improvement are discussed in the Opportunities for Improvement section (pages 4–9). For these activities, we made recommendations for improvement. Recommendations pertain to issues that are significant enough to be monitored by the OIG until corrective actions are implemented.

During this review, we also presented fraud and integrity awareness briefings for 231 employees. These briefings covered procedures for reporting suspected criminal activity to the OIG and included case-specific examples illustrating procurement fraud, false claims, conflicts of interest, and bribery.

Results of Review

Organizational Strength

State-of-the-Art Psychiatric Unit. The Waco Division developed a new, state-of-the-art Acute Psychiatric Unit, which included 6 triage beds and 56 acute care beds. Interior design elements provided an aesthetically calming environment for patients. Safety features unique to this facility included a dedicated elevator for transporting psychiatric patients from the ambulance entrance to the Triage Unit.

Other safety features included two-way doors to prevent staff entrapment and to provide emergency access into rooms. Door hinges, shower heads and curtains, door handles, hard ceilings, and wardrobe hardware were designed to prevent suicides. Exterior windows and light fixtures were constructed for high-impact strength and durability. Showers and water sources were controlled from the nurses' station to prevent possible flooding of rooms. All electrical switches and outlets were tamper-proof, and nursing staff used a special key to turn off electricity in patient rooms.

The nurses' stations were designed for maximum observation of the patient environment and included a high-impact, clear plastic barrier, recessed computers, drawer locks, and electronic controls for entrance and exit doors. The locks were tied to the fire alarm system for automatic release in case of fire. A security camera surveillance system enabled staff to closely monitor access throughout the building. Panic alarm systems were placed in offices and throughout the building so staff could request assistance in dangerous situations. All of these enhancements contributed to a safe physical environment for patients and staff.

Opportunities for Improvement

Quality Management – Performance Improvement and Review Processes Should Be Strengthened

Condition Needing Improvement. Senior managers needed to establish priorities for performance improvement and standardize review processes. The QM program generally provided appropriate oversight of patient care; however, it was difficult to determine the effectiveness of performance improvements because data analysis was not consistent, actions were not clearly defined, and reports were not concise. Program managers needed to analyze pertinent data in all areas required by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). JCAHO requires hospitals to analyze data for trends and make recommendations to improve patient care.

To evaluate the QM program, we assessed the program structure, data analysis, benchmarking, recommendations, and evaluation of corrective actions for performance improvement, utilization management, and patient safety. We interviewed appropriate employees and reviewed policies, plans, committee minutes, and reports.

QM Performance Improvement. There was a lack of consistency and standardization of reporting among the program components. It was difficult to follow committee minutes because there was no standardized, systematic reporting format. Not all reports identified action items and assigned responsibility and time frames for completion and re-evaluation.

The Health Care System Director was appointed in October 2004 and had identified changes to improve the program. He agreed with our findings and was in the process of recruiting a permanent QM Coordinator.

QM Review Processes. Review processes required by the Veterans Health Administration (VHA) and JCAHO were not in place or were inadequate in the following areas:

- Designated oversight committees did not analyze medication errors and falls to identify opportunities for improvement.
- Mortality rates, adverse events from moderate sedation, and outcomes of resuscitation had not been trended or analyzed consistently.
- The patient safety coordinator assigned a safety assessment code for each reportable incident, as required by VHA, but did not trend the incidents over time.
- When QM reviews identified problems, program managers did not consistently identify appropriate corrective actions.

Health care system management needed to ensure that QM personnel collect, trend, and analyze data and identify appropriate corrective actions to improve care in all areas.

Recommended Improvement Action 1. We recommended that the VISN Director ensure that the Health Care System Director takes action to develop an organized QM program that will: (a) review pertinent patient care processes, (b) trend and analyze all data, (c) identify appropriate corrective actions with assigned timeframes and responsibility, and (d) communicate results in a standardized format through designated oversight committees.

The VISN and Health Care System Directors agreed with the findings and recommendations and reported that staff would review pertinent patient care processes, trend and analyze all data, identify appropriate corrective actions with assigned timeframes and responsibility, and communicate results in a standardized format through designated oversight committees. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

Service Contracts – Contracting Activities Needed Improvement

Condition Needing Improvement. The health care system needed to request legal and technical reviews and preaward audits of service contracts when required and ensure contract files included required documents.

To evaluate contracting activities, we reviewed 14 noncompetitive and 6 competitive service contracts valued at about $13 million. Our review showed that contracting officers (COs) had appropriate warrant authorities, contract files were generally well organized, and COs and contracting officer's technical representatives (COTRs) had received appropriate acquisition training. However, we identified two issues requiring management attention.

Legal and Technical Reviews and Preaward Audits Not Requested. VHA policy requires that the VA Office of Acquisition and Materiel Management perform legal and technical reviews of all noncompetitive contracts valued at $500,000 or more and of all competitive contracts valued at $1.5 million or more. In addition, VHA policy requires that all noncompetitive contracts with affiliated medical schools valued at $500,000 or more be sent to the OIG Contract Review and Evaluation Division for preaward audits. The primary purpose of a preaward audit is to determine whether the prices are fair and reasonable. Our review identified three contracts that required legal and technical reviews and two contracts that required preaward audits.

However, none of the required reviews or audits had been requested. We estimated that preaward audits would have resulted in cost savings of $179,025. [1]

Contract Documentation Not Complete. The Federal Acquisition Regulation requires COs to ensure that contract files contain all relevant contract documentation. Although the files we reviewed generally included appropriate documentation, 6 of the 20 files did not contain all of the required documents. The files for four contracts did not contain price negotiation memorandums, one file did not contain a COTR designation letter, and another file contained a COTR designation letter that was not signed by the COTR.

Recommended Improvement Action 2. We recommended the VISN Director ensure that the Health Care System Director requires contracting staff to: (a) request legal and technical reviews and preaward audits when required and (b) include all required documentation in contract files.

The VISN and Health Care System Directors agreed with the findings and recommendations and reported that contracting personnel have been reminded of the need to request legal and technical reviews and preaward audits when required and to include all required documentation in contract files. The Chief of Purchasing and Contracting will monitor contract files to ensure that these requirements are met. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

Supply Inventory Management – Inventory Controls Should Be Strengthened

Condition Needing Improvement. The health care system needed to maintain accurate inventory records and reduce stock levels of supplies. VHA policy requires that medical facilities use the automated Generic Inventory Package (GIP) and the Prosthetics Inventory Package (PIP) to manage inventories. At the time of our review, GIP and PIP data showed the health care system's supply inventory included 5,924 line items valued at about $1.2 million.

Inaccurate Inventory Records. The health care system was not maintaining accurate inventory records. To assess the accuracy of GIP and PIP data, we inventoried 45 medical, 21 engineering, and 19 prosthetics line items with a combined recorded value of $212,372. The stock levels recorded in GIP and PIP were inaccurate for 32 of the 85 (38 percent) line items, with 21 shortages valued at $16,764 and 11 overages valued at $6,189. The inaccurate inventory records occurred primarily because health care system

[1] The OIG has determined that preaward audits have historically resulted in potential average savings of 21 percent of the total value of proposed contract prices. The OIG has also determined that 62 percent of the potential cost savings has been sustained during contract negotiations. Applying these percentages to the total estimated value of the contracts ($1,375,000 x 21 percent x 62 percent) resulted in estimated cost savings of $179,025.

personnel did not promptly record receipts and distributions of supplies. Inaccurate inventory records hinder efforts to maintain appropriate stock levels.

Excess Stock. The health care system needed to reduce stock levels of supplies. To determine if stock levels exceeded VHA's 30-day supply goal, we compared the quantities on hand to usage data for the 85 line items that we inventoried. We found that the health care system needed to reduce stock levels for 15 of the 85 (18 percent) line items. The value of the excess stock was $13,678, which was about 6 percent of the total reported value ($212,372) of the 85 items. By applying 6 percent to the value of the entire supply inventory, we estimated that the value of the excess stock was $74,641.

Recommended Improvement Action 3. We recommended the VISN Director ensure the Health Care System Director takes action to: (a) reconcile differences and correct inventory records as appropriate, (b) record receipts and distributions promptly, and (c) reduce stock levels to meet the 30-day supply goal.

The VISN and Health Care System Directors agreed with the findings and recommendations and reported that the need to reconcile differences, correct inventory records, and record receipts and distributions promptly has been emphasized to inventory managers. Managers will review inventory records monthly to ensure accuracy. An inventory of prosthetic items will be completed by June 2005, and a barcoding patch will be installed, which will aid prosthetics personnel in maintaining accurate inventory records. In addition, the health care system has reduced stock levels to meet the 30-day stock on hand requirement for all of the excess supply items identified in our review. The improvement plans are acceptable, and we will follow up on planned actions until they are completed.

Medical Care Collections Fund – Collections Could Be Increased

Condition Needing Improvement. The health care system could increase MCCF collections by identifying veterans' insurance information at the time of treatment, improving documentation of medical care, ensuring that MCCF personnel identify all billable VA care, promptly submitting the documentation of fee-basis care to MCCF personnel, and issuing bills to insurance carriers promptly.

Under the MCCF program, VA is authorized to recover from health insurance carriers the cost of treating insured veterans. In FY 2004, the health care system collected $15.2 million, which was 88 percent of its collection goal of $17.3 million.

Insurance Information Not Obtained Promptly. Health care system managers needed to ensure that eligibility clerks and clinic clerks obtain insurance information from veterans at the time of treatment so that MCCF personnel can bill insurance carriers promptly. We reviewed the records of 10 veterans from the September 2004 "Detailed Patients with Unidentified Insurance Report" to determine whether the health care system was

obtaining insurance information promptly. At our request, MCCF personnel contacted the 10 veterans and determined that 5 had insurance. Although we did not find any missed billing opportunities related to these veterans, delays in obtaining insurance information could result in denied claims because insurance carriers impose time limits for submitting claims.

Care Not Properly Documented. Medical care providers needed to improve the documentation of care. The "Reasons Not Billable Report" lists episodes of care that MCCF personnel could not bill because, among other reasons, medical care providers did not adequately document the care in veterans' medical records. We reviewed 45 potentially billable episodes of care totaling $83,165 listed on the report for the 6-month period ending September 30, 2004. We identified 33 episodes of care with 40 missed billing opportunities totaling $31,705 that MCCF personnel could have billed if medical documentation had been complete.

Billable VA Care Not Identified. MCCF personnel could increase collections by doing a better job of identifying billable VA care. To determine whether MCCF personnel identified all billable VA care, we reviewed 40 episodes of care: 15 inpatient discharges that occurred during September 2004, 15 outpatient visits that occurred on September 15, 2004, and 10 potentially billable episodes of care listed on the "Unbilled Amounts Detailed Report" for the 6-month period ending September 30, 2004. We identified 13 episodes of care with 31 missed billing opportunities for VA care totaling $70,856.

Fee-Basis Documentation Not Forwarded Promptly. MCCF personnel missed opportunities to bill for fee-basis care because the Fee-Basis Unit did not forward required documentation promptly. The Fee-Basis Unit authorizes payments to non-VA medical care providers furnishing fee-basis care to veterans. After authorizing payments for care furnished to veterans with insurance, the Fee-Basis Unit forwards appropriate documentation to MCCF personnel, who bill the insurance carriers. To determine whether MCCF personnel properly billed insurance carriers for fee-basis care, we reviewed the records for 15 episodes of care furnished during FY 2004. We identified 4 episodes of care with 10 missed billing opportunities totaling $8,075. Because the Fee-Basis Unit did not forward the required documentation promptly, MCCF personnel missed the insurance carriers' deadlines to bill for this care.

Bills Not Issued Promptly. MCCF personnel did not issue bills promptly to insurance carriers. We reviewed the records of 10 potentially billable episodes of care listed on the "Unbilled Amounts Detailed Report" for the 6-month period ending September 30, 2004, and 15 outpatient visits that occurred on September 15, 2004. Although the VA goal is to issue bills within 45 days after treatment, we found 14 billing delays ranging from 98 to 193 days. According to the MCCF Coordinator, the delays occurred because the health care system has a substantial coding backlog. Because insurance carriers impose time limits on claims, the health care system needs to ensure that it eliminates the coding backlog so that billing delays do not result in denied claims.

Potential Collections. We estimated that additional bills totaling $110,636 ($31,705 + $70,856 + $8,075) could have been issued for the missed billing opportunities we identified. Based on the health care system's historical collection rate of 36.9 percent, MCCF personnel could have increased collections by $40,825 ($110,636 x 36.9 percent). As a result of our review, MCCF personnel issued 56 bills during our visit, and they were working to issue additional bills for the missed billing opportunities we identified.

Recommended Improvement Action 4. We recommended the VISN Director require the Health Care System Director to ensure that: (a) eligibility clerks and clinic clerks identify insurance information at the time of treatment, (b) medical care providers adequately document the care provided in veterans' medical records, (c) all billable VA care is identified and billed, (d) the Fee-Basis Unit promptly forwards the documentation required for billing insurance carriers to MCCF personnel, and (e) MCCF personnel take action to eliminate the coding backlog and issue bills to insurance carriers promptly.

The VISN and Health Care System Directors agreed with the findings and recommendations and reported that refresher training on obtaining insurance information will be provided to all eligibility and clinic clerks. Lead coders are conducting monthly audits to identify medical care documentation deficiencies and reporting the results to clinical service chiefs and the Chief of Staff for immediate corrective action. Medical personnel have been provided training on how to adequately document care in medical records, and follow-up training will be provided as needed. MCCF personnel have been provided refresher training on billing procedures and claims tracking. On a weekly basis, the Chief of MCCF is reviewing the "Unbilled Amounts Detailed Report" and providing feedback to MCCF personnel on items that need to be billed. The health care system has a new process in place to ensure the Fee-Basis Unit promptly forwards the documentation required for billing insurance carriers to MCCF personnel. In addition, the health care system is monitoring the coding backlog and expects to have it eliminated by December 2005. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

Appendix A

VISN 17 Director Comments

Department of Veterans Affairs **Memorandum**

Date: April 18, 2005

From: VISN 17 Director

Subject: **Central Texas Veterans Health Care System**

To: Director, Dallas Audit Operations Division

Network 17 appreciates the OIG's review and recommendations concerning the VA Central Texas Health Care System (CTHCS). The VISN office takes seriously the findings and recommended improvement actions. We are confident that the action plan put forward by CTHCS will appropriately address the issues identified. We welcome the OIG to return to CTHCS to review the improvements.

(original signed by:)

Thomas J. Stranova

Network Director, VISN 17

Appendix B

Health Care System Director Comments

Department of Veterans Affairs **Memorandum**

Date: April 12, 2005

From: Health Care System Director

Subject: **Central Texas Veterans Health Care System**

To: Director (10N17), Heart of Texas Veterans Health Care Network, Arlington, TX

ATTN: Karen Spada

1. I want to express my appreciation to the Office of Inspector General (OIG) Survey Team for their professional, and comprehensive Combined Assessment Program (CAP) review January 10-14, 2005. I have reviewed the draft report for Central Texas Veterans Health Care System and concur with the findings and recommendations, and with all comments and planned actions.

2. I appreciate the opportunity for this review as a continuing process to improve the care to our veterans.

(original signed by:)

Bruce A. Gordon

Health Care System Director's Comments to Office of Inspector General's Report

The following Health Care System Director's comments are submitted in response to the recommendations in the Office of Inspector General's report:

OIG Recommendations

Recommended Improvement Action 1. We recommended that the VISN Director ensure that the Health Care System Director takes action to develop an organized QM program that will: (a) review pertinent patient care processes, (b) trend and analyze all data, (c) identify appropriate corrective actions with assigned timeframes and responsibility, and (d) communicate results in a standardized format through designated oversight committees.

Concur **Target Completion Date:** July 2005

a) Review pertinent patient care processes.

IMPLEMENTATION: Quality Management & Improvement Service reviewed all pertinent patient care processes in March 2005 and validated that each pertinent patient care process is reviewed and reported within the medical center's formal committee structure. System Plan for Performance Improvement policy will document responsibility for ongoing monitoring.

TARGET DATE: May 2005.

b) Trend and analyze all data.

IMPLEMENTATION: A grid that establishes responsibility for data collection/analysis is being developed. Finally, a series of classes on what and how to collect appropriate data has been initiated and will be ongoing.

Trending and analysis of cited deficiencies will be reported through the Patient Safety Council, Medical Staff Executive Council, Invasive Procedures Oversight Committee, and Critical Care Committee

TARGET DATE: June 2005.

c) Identify appropriate corrective actions within assigned timeframes and responsibility.

IMPLEMENTATION: Cited deficiencies will be corrected by issuing a new policy which formally states roles and responsibilities of all committees and subcommittees. Emphasis will be placed on collecting, trending, and analyzing data and corrective actions. Appropriate responsible individuals and deadlines along with evaluating the effectiveness of actions will also be included. Finally, a policy will be published standardizing a format for minutes.

TARGET DATE: July 2005.

d) Communicate results in a standardized format through designated oversight committees.

IMPLEMENTATION: A standardized format for communicating QA study results to designated oversight committees is being developed.

TARGET DATE: July 2005.

Recommended Improvement Action 2. We recommended the VISN Director ensure that the Health Care System Director requires contracting staff to: (a) request legal and technical reviews and preaward audits when required and (b) include all required documentation in contract files.

Concur **Target Completion Date:** April 2005

a) Request legal and technical reviews and preaward audits when required.

IMPLEMENTATION: All staff have been reminded of this requirement and given a printout of General Counsel's web page detailing legal/tech review requirements. The Chief of Purchasing & Contracting will conduct ongoing reviews of contract files to ensure compliance with this requirement.

TARGET DATE: April 2005.

b) Include all required documentation in contract files.

IMPLEMENTATION: All staff have been reminded to fully document their contract files in accordance with regulations. The Chief of Purchasing & Contracting will conduct ongoing reviews of contract files to ensure compliance with this requirement.

TARGET DATE: April 2005.

Recommended Improvement Action 3. We recommended the VISN Director ensure the Health Care System Director takes action to: (a) reconcile differences and correct inventory records as appropriate, (b) record receipts and distributions promptly, and (c) reduce stock levels to meet the 30-day supply goal.

Concur **Target Completion Date:** June 2005

a) Reconcile differences and correct inventory records as appropriate.

IMPLEMENTATION: GIP managers have been reminded to review reports and correct inventory records if needed. Records will be reviewed monthly to ensure accuracy.

TARGET DATE: April 2005.

IMPLEMENTATION: Prosthetic inventory will be made by the end of June 2005 to facilitate the loading of the mandatory bar coding patch.

TARGET DATE: June 2005.

b) Record receipts and distributions promptly.

IMPLEMENTATION: GIP managers have been reminded of the importance of processing receipt and issue documents promptly.

TARGET DATE: April 2005.

IMPLEMENTATION: Prosthetics staff were trained to address timely posting of receipts. Installation of barcoding patch will assist with the accuracy of posting. Training for utilization of barcode scanners will be completed by June 2005.

TARGET DATE: June 2005.

c) Reduce stock levels to meet the 30-day supply goal.

IMPLEMENTATION: The monitors for maintaining 30-day stock level has been suspended by VHA per memorandum dated January 20, 2005 entitled "Suspension of Contract Hierarchy and Inventory Management Performance Monitors (EDMS No. 300116) from Deputy Under Secretary for Health for Operations and Management (10N). The OIG CAP review in CTVHCS was conducted the week of January 10, 2005, prior to the issuance of the new Inventory Management guidance. New guidelines are being developed by 10N and will be published. Upon receipt of revised guidelines, CTVHCS will ensure compliance. CTVHCS is currently in compliance with the 30-day stock on hand requirement in all areas with the exception of FMS. Performance monitors in FMS have been suspended.

TARGET DATE: April 2005.

Recommended Improvement Action 4. We recommended the VISN Director require the Health Care System Director to ensure that: (a) eligibility clerks and clinic clerks identify insurance information at the time of treatment, (b) medical care providers adequately document the care provided in veterans' medical records, (c) all billable VA care is identified and billed, (d) the Fee-Basis Unit promptly forwards the documentation required for billing insurance carriers to MCCF personnel, and (e) MCCF personnel take action to eliminate the coding backlog and issue bills to insurance carriers promptly.

Concur **Target Completion Date:** Dec 2005

a) Eligibility clerks and clinic clerks should identify insurance information at the time of treatment.

IMPLEMENTATION: Refresher and ongoing training will be provided to all eligibility and clinic clerks on how to correctly obtain insurance information. The importance of this information is conveyed during training so employees realize delays in obtaining insurance information could result in denied claims due to insurance carriers' imposed time limits for submitting claims. Insurance information is collected at the time of registration of new patients. Established patients are pre-registered at outpatient appointments, which includes collecting insurance information. VHA posters have been placed in primary care and specialty clinic areas asking the veterans to report their health insurance information. Monitoring of the intake report (patients with unidentified insurance) on a weekly basis is occurring. We are at 100 percent compliance with the question being answered.

TARGET DATE: June 2005.

b) Medical Care providers should adequately document the care provided in the veterans' medical records.

IMPLEMENTATION: Monthly Compliance & Business Integrity (CBI) audits are conducted by the lead coders to identify medical record deficiencies of providers and provide feedback to the appropriate clinical Service Chief for immediate corrective action. Results of the audits are provided to the Chief of Staff for monitoring of compliance. The coding department has provided training to medical staff on how to adequately document care in the medical record. The importance of this documentation was stressed in terms of potential billable episodes of care that were not recoverable due to inadequate documentation. Follow-up training will be provided based upon the results of the CBI audits.

TARGET DATE: July 2005.

c) All billable VA care should be identified and billed.

IMPLEMENTATION: Refresher training has been provided and is ongoing for billing procedures and claims tracking. The Chief of Staff is monitoring frequency of late checkouts, which prevent the episodes from being entered into the Integrated Billing package. The Chief, MCCF will institute a weekly process to review and analyze the Unbilled Amounts Detailed Report and provide feedback to employees to identify CPT codes which need to be billed. The auto biller is programmed to set up bills to be processed in 13 days from encounters.

TARGET DATE: August 2005.

d) The Fee-Basis Unit should promptly forward the documentation required for billing insurance carriers to MCCF personnel.

IMPLEMENTATION: An improved process is now in place whereby the supervisor of the Fee Basis Unit monitors daily claims received to ensure veteran has insurance coverage for that episode of care. Within established timeframe, documents are forwarded to MCCF. A review process is in place to ensure documentation. A tracking process is in place for a suspense to be maintained in the Fee Basis Unit to ensure timely return from MCCF to bill the insurance carrier.

TARGET DATE: May 2005.

e) MCCF personnel should take action to eliminate the coding backlog and issue bills to insurance carriers promptly.

IMPLEMENTATION: The Acting Chief, Patient Financial & Support Service will institute a weekly process where the status of backlog coding is assessed. Both the Chief, HIMS and Chief, MCCF are cognizant the consequences of failure to bill in a timely manner will result in denial of claims by insurance carriers. Improvement has been made in reducing the backlog with the expectation to be compliant with the goal of 45 days to be billed after treatment.

TARGET DATE: December 2005.

Appendix C

Monetary Benefits in Accordance with IG Act Amendments

Recommendation	Explanation of Benefit(s)	Better Use of Funds
2a	Preaward audits would result in reduced contract prices.	$179,025
3c	Reducing stock levels would make funds available for other uses.	74,641
4b, c	Improving documentation of care and ensuring all billable VA care is billed would increase MCCF collections.	40,825
	Total	$294,491

OIG Contact and Staff Acknowledgments

OIG Contact	Linda DeLong, Director, Dallas Regional Office of Healthcare Inspections, 214-253-3331
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Appendix E

Report Distribution

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Non-VA Distribution

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This report will be available in the near future on the OIG's Web site at http://www.va.gov/oig/52/reports/mainlist.htm. This report will remain on the OIG Web site for at least 2 fiscal years after it is issued.